Risk Essentials

Accident investigation report template

It is essential to understand that the processes associated with the accident/incident investigation (AI) report will contribute to the identification and implementation of remedial actions to prevent accident/incident reoccurrence; in addition, the AI report is a critical document in the event of a criminal prosecution or civil liability claim. An AI report is one key piece of evidence to manage a civil liability claim. The AI report is a disclosable document when a civil liability claim is litigated and should capture relevant facts and appropriate/missing documentation so the correct decision on liability can be made quickly and efficiently. It's vitally important that only facts are recorded within the accident investigation report. Recording hearsay, uncorroborated evidence and opinions can negatively impact the management of a civil liability claim and the outputs of the accident investigation process.

The purpose of this form is to record all accident or incident events. The term accident is used where injury or ill health occurs. The term incident includes near-misses and undesired circumstances where there is the potential for injury.

- **Part 1** should be filled out immediately by the manager or supervisor for the work activity involved.
- **Part 2** should be completed by the person responsible for health and safety.
- **Part 3** should be completed, where appropriate, by the investigation team.
- The investigating team and managers should complete **parts 4 & 5** with the authority to make decisions.
- **Part 6**, the appendices section of this report, should always be populated as the information within is vital to the civil liability claims management process.

Note: guidance text is highlighted with an orange outline within this document.

QBE

Part 1

Overview

Reference number

Reported by

Employee position

Name and role of injured person

Date of adverse event

/ /

Time

Type of event

☐ Incident ☐ Ill health ☐ Minor injury ☐ Serious injury ☐ Specified injury

Site address

Location of accident

Brief details of event circumstances (what, where, when, who and emergency measures taken)

Name of witness(es)	Contact details

Reported to

Date

/ /

Time

Time lost event day (first day of absence)

/ /

Injured person return-to-work date

Part 2

Initial assessment

(To be carried out by the local health-and-safety-nominated person)

The decision to investigate

The table below will assist you in determining the level of investigation which is appropriate for the adverse event. Remember you must consider the worst potential consequence of the adverse event (e.g. a scaffold collapse may not have caused injuries but had the potential to cause major or fatal injuries).

	Potential worst consequences of adverse event			
Likelihood of recurrence	**Minor**	**Serious**	**Major**	**Fatal**
Certain	☐	☐	☐	☐
Likely	☐	☐	☐	☐
Possible	☐	☐	☐	☐
Unlikely	☐	☐	☐	☐
Rare	☐	☐	☐	☐

Risk	Minimal	Low	Medium	High
Investigation level	Minimal level	Low level	Medium level	High level

Further information on this process can be found within HSG245. The link is provided below:
www.hse.gov.uk/pubns/hsg245.pdf

Part 2

Initial assessment

Actual/potential for harm

☐ Fatal ☐ Major ☐ Serious ☐ Minor ☐ Damage only

RIDDOR-reportable?

☐ Yes ☐ No

RIDDOR reported to the HSE?

☐ Yes ☐ No

If 'yes', please provide the date

/ /

Reported by

Via

☐ Phone ☐ Online

Call received by an HSE inspector?

☐ Yes ☐ No

Has an entry been made into the accident book?

☐ Yes ☐ No

If 'yes', please provide the date

/ /

Reference

Investigation level

☐ High level ☐ Medium level ☐ Low level ☐ Minimal level

Initial accident assessment carried out by

Date

/ /

Further investigation required?

☐ Yes ☐ No

Priority

For investigation by

Part 3

Investigation information gathering

Where did the adverse event happen?

Date of adverse event

/ /

Time

Who was injured/suffered ill health or was otherwise involved with the adverse event?

How did the adverse event happen? (Note any equipment, substances or articles involved.)

What activities were being carried out at the time?

Was there anything unusual or different about the working conditions?

Were there adequate safe working procedures, and were they followed?
(Inclusive of monitoring arrangements and supervision.)

What injuries or ill-health effects, if any, were caused?

If there was an injury, how did it occur, and what caused it?

Part 3

Investigation information gathering

Was the risk known? If so, why wasn't it controlled? If not, why not?

Did the organisation and arrangement of the work influence the adverse event?
(Noting any changes to process or environment.)

Was maintenance and cleaning sufficient? If not, explain why not.

Were the people involved competent and suitable?

Did the workplace layout influence the adverse event?

Did the nature or shape of the materials influence the adverse event?

Did difficulties using the plant and equipment influence the adverse event?

Was the safety equipment suitable and sufficient? (For example, machinery guarding, PPE, etc.)

Did other conditions influence the adverse event? (Environmental factors e.g., weather, lighting, work hours.)

Part 4

Root cause analysis

This section of the accident investigation report template focuses on root cause analysis. The primary objective of root cause analysis is to identify immediate, underlying and root causes so that measures can be implemented to prevent recurrence. See below the definitions of the aforementioned elements:

- **Immediate causes** – the most obvious reason why an adverse event occurs.
- **Underlying causes** – the less obvious system or other failures.
- **Root causes** – initiating events from which all other failings or causes spring.

There are many root cause analysis models that can be utilised within the accident investigation process, such as fault tree analysis and failure mode and effect analysis. When conducting accident investigations, these models can effectively identify immediate, underlying, and root causes. Many more root cause analysis methodologies can be applied to accident investigations, but we cannot address each within this guidance document. See the links below for further information on the aforementioned models.

- www.safetyculture.com/topics/fault-tree-analysis/
- www.hsestudyguide.com/failure-mode-effect-analysis-fmea/#:~:text=It%20involves%20identifying%20failure%20modes,before%20they%20lead%20to%20accidents

In addition, a helpful method is the fishbone methodology, which is regularly utilised in multiple industries. A fishbone diagram root cause analysis visually represents an accident/incident and its possible causes, which can facilitate communication and collaboration with team members and stakeholders to identify immediate, underlying, and root causes. Further information on the fishbone diagram root cause analysis model can be found in the following link:

- www.designorate.com/problem-solving-cause-and-effect-diagram/

Further information on the 5 Whys root cause analysis model can be found within the following link:

- https://aqua.nhs.uk/wp-content/uploads/2023/07/qsir-using-five-whys-to-review-a-simple-problem.pdf

Part 5

Findings and remedial actions

Once the root cause analysis has been completed, remedial actions will have been identified to prevent reoccurrence.

Remedial actions

01	
02	
03	
04	
05	
06	
07	
08	
09	
10	

Do similar risks exist elsewhere? If so, what and where?

Have similar adverse events happened before? If so, give detail.

Part 5

The risk control action plan

Who will take responsibility for remedial actions? (Include timescales)

	Control measure	Expected completion date	Person responsible
01		/ /	
02		/ /	
03		/ /	
04		/ /	
05		/ /	
06		/ /	
07		/ /	
08		/ /	

Which risk assessments and safe working and management procedures need to be reviewed and updated?

	Name of risk assessment and safe working procedure	Expected completion date	Person responsible
01		/ /	
02		/ /	
03		/ /	
04		/ /	
05		/ /	
06		/ /	
07		/ /	
08		/ /	

Part 5

The risk control action plan

Have the adverse event details and the investigation findings been recorded and analysed?
Are there any trends or common causes that suggest further investigation? What did the adverse event cost?

Signed on behalf of the investigation team	**Name and position**

Members of the investigation team	**Position**

The findings of this investigation need to be communicated to the following managers, union and employee safety representatives.

Person	**Position**	**Date**
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /

Part 6

Appendices

A	
B	
C	
D	
E	
F	
G	
H	
I	
J	
K	
L	
M	
N	
O	
P	
Q	
R	
S	
T	

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